TENNESSEE DEPARTMENT OF HUMAN SERVICES
DIVISION OF REHABILITATION SERVICES – CLIENT MASTER RECORD 1-2

APPLICATION FOR VOCATIONAL REHABILITATION

PART 1

A. Office No. ☐☐ **B. Counselor No.** ☐☐☐ **C. Applicant SSN** ☐☐☐-☐☐-☐☐☐☐

D. Name _____
Last First Middle

E. Address _____ ☐☐ _____ ☐☐☐☐☐
Street City County State Zip Code

F. Phone No. ☐☐☐-☐☐☐-☐☐☐☐ **G. Referral Date** ☐☐-☐☐-☐☐

H. Birthdate ☐☐-☐☐-☐☐ **I. Age** _____ **J. Referral Source** ☐☐ _____

K. Disability ☐☐☐ ☐☐☐☐ _____
(Old Code Format) (New Code Format)

Cause of Disability: _____ **Age at beginning of disability:** _____

How does the disability limit activities? _____

Other physical or mental problems: _____

Have you previously received VR Services? Yes ☐ No ☐ **State** _____ **Date** _____

L. Gender ☐ M – Male F – Female **M. Where were you born?** _____

PART 2

A. Race/Ethnicity (Y –Yes N-No)

White	☐	Black or African-American	☐	American Indian or Alaska Native	☐
Asian	☐	Native Hawaiian or Other Pacific Islander	☐	Hispanic or Latino	☐

B. Education (Highest grade completed) ☐ **Year** _____ **C. Individual has an IEP?** ☐ **(Y-Yes , N-No)**

Name & Address: _____

Other Training: _____

D. Marital Stat ☐ 1–M, 2–W, 3– Div, 4–Sep, 5-NM **E. No. Dep** ☐☐ **F. Vet: Yes** ☐ **No** ☐ **G. Emp Stat** ☐☐

H. H. Wkly Earnings ☐☐☐☐ **I. Hrs Wrk'd** ☐☐ **J. Prim Src of Support** ☐ **K. Living Arrangements** ☐☐

L. Public Support:

				Benefit Amount					Benefit Amount
SSI-Aged	Yes	☐	No ☐		SSDI	Yes	☐	No ☐	
SSI-Blind or Disabled	Yes	☐	No ☐		VA Disability	Yes	☐	No ☐	
Families First	Yes	☐	No ☐		Worker's Comp	Yes	☐	No ☐	
General Assistance	Yes	☐	No ☐		Other PA/PS	Yes	☐	No ☐	

M. Medical Insurance: (Y-Yes, N-NO)

TennCare	☐	Medicare	☐	Public Insurance thru Other Sources	☐	Private Insurance Thru own Employer	☐	Private Insurance Thru Other Means	☐

Name of Private Coverage _____

N. Alternate Phone No. ☐☐☐-☐☐☐-☐☐☐☐ (Optional)

O. E-mail Address: _____ (Optional)

Name and Address of Physicians and Dates Seen for Disability:

_____ _____

_____ _____

_____ _____

_____ _____

Date Last Hospitalized: _____ Hospital: _____

Reason: _____

Are there other people living in the home? Yes ☐ No ☐ Relationship & Number _____

Have you ever worked for pay or profit? Yes ☐ No ☐ If yes, what year did you last work? ☐☐☐☐

List Last 3 Employers:

Employer	Address	Job Title	Employment Dates	Weekly Wage	Reason for Leaving

Other Work Experience:

_____

Area of Vocational Interest: _____

List 2 persons (Other than listed in home) who would always know your address:

Name: _____ Address: _____ Phone: _____ (Include Area Code)

Name: _____ Address: _____ Phone: _____ (Include Area Code)

Comments:

_____

_____

_____

_____

I hereby make application for services I may be eligible to receive so that I may enter employment.

Signature of Applicant: _____ Date: ☐☐-☐☐-☐☐

Signature of Parent or Guardian (if required): _____ Date: _____

Signature of Counselor: _____ Date: _____